		FOR OHF USE					

LL1

2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0008409

Facility Name: Eunice C. Smith Nursing Home

Address: 1251 College Ave. (Number) Alton (City) 62002 (Zip Code)

County: Madison

Telephone Number: (618) 463-7330 **Fax #**

IDPA ID Number: 37-0661172

Date of Initial License for Current Owners: 12/30/66

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Paul Bradshaw **Telephone Number:** (314) 653-5366

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/0102 to 12/31/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) Gladys A. Sullivan
(Title) Administrator

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Eunice C. Smith Nursing Home # 0008409 Report Period Beginning: 01/0102 Ending: 12/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	64	Skilled (SNF)	64	23,360	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	64	TOTALS	64	23,360	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	2,632	19,443	142	22,217	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	2,632	19,443	142	22,217	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.11%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 12/30/66

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 1 and days of care provided 0

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31 Fiscal Year: 12/31

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Eunice C. Smith Nursing Home # 0008409 **Report Period Beginning:** 01/0102 **Ending:** 12/31/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	A. General Services											
1	Dietary		225,429	53,710	279,139		279,139	275,554	554,693			1
2	Food Purchase											2
3	Housekeeping	90,641	8,486	13,068	112,195		112,195		112,195			3
4	Laundry	15,110	42	56,225	71,377		71,377		71,377			4
5	Heat and Other Utilities			68,980	68,980		68,980		68,980			5
6	Maintenance	34,935		32,100	67,035		67,035		67,035			6
7	Other (specify):* Cafeteria							15,178	15,178			7
8	**TOTAL General Services**	140,686	233,957	224,083	598,726		598,726	290,732	889,458			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,147,075	37,458	12,106	1,196,639		1,196,639	9,539	1,206,178			10
10a	Therapy	14,776	262	1,600	16,638		16,638		16,638			10a
11	Activities											11
12	Social Services	57,425	1,799	6,543	65,767		65,767		65,767			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,219,276	39,519	20,249	1,279,044		1,279,044	9,539	1,288,583			16
	C. General Administration											
17	Administrative	122,590	6,541	199,739	328,870		328,870	(9,798)	319,072			17
18	Directors Fees											18
19	Professional Services											19
20	Dues, Fees, Subscriptions & Promotions			4,874	4,874		4,874	(1,534)	3,340			20
21	Clerical & General Office Expenses							2,197	2,197			21
22	Employee Benefits & Payroll Taxes			333,094	333,094		333,094		333,094			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,197	1,197		1,197		1,197			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			36,671	36,671		36,671		36,671			26
27	Other (specify):*											27
28	**TOTAL General Administration**	122,590	6,541	575,575	704,706		704,706	(9,135)	695,571			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,482,552	280,017	819,907	2,582,476		2,582,476	291,136	2,873,612			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Eunice C. Smith Nursing Home #0008409 Report Period Beginning: 01/0102 Ending: 12/31/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			104,611	104,611		104,611		104,611			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			10,698	10,698		10,698		10,698			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			115,309	115,309		115,309		115,309			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	2,355	22,834	20	25,209		25,209		25,209			39
40	Barber and Beauty Shops			10,362	10,362		10,362		10,362			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee							35,040	35,040			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	2,355	22,834	10,382	35,571		35,571	35,040	70,611			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,484,907	302,851	945,598	2,733,356		2,733,356	326,176	3,059,532			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Eunice C. Smith Nursing Home # 0008409 Report Period Beginning: 01/0102 Ending: 12/31/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(9,798)	17		24
25	Fund Raising, Advertising and Promotional	(1,534)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Provider Participation Fee	35,040	42		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 23,708		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 23,708		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS **Page 5A**

Eunice C. Smith Nursing Home

ID# **0008409**

Report Period Beginning: **01/0102**

Ending: **12/31/02**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Dietary	$		1
2	Housekeeping			2
3	Plant Operations			3
4	Laundry			4
5	Medical Records			5
6	Cafeteria			6
7	Therapy Services			7
8	Ancillary Services			8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Eunice C. Smith Nursing Home # 0008409 **Report Period Beginning:** 01/0102 **Ending:** 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	275,554	0	0	0	0	0	0	0	0	0	275,554	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	15,178	0	0	0	0	0	0	0	0	0	15,178	7
8	**TOTAL General Services**	0	290,732	0	0	0	0	0	0	0	0	0	290,732	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	9,539	0	0	0	0	0	0	0	0	0	9,539	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	9,539	0	0	0	0	0	0	0	0	0	9,539	16
	C. General Administration													
17	Administrative	(9,798)	0	0	0	0	0	0	0	0	0	0	(9,798)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(1,534)	0	0	0	0	0	0	0	0	0	0	(1,534)	20
21	Clerical & General Office Expenses	0	2,197	0	0	0	0	0	0	0	0	0	2,197	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(11,332)	2,197	0	0	0	0	0	0	0	0	0	(9,135)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(11,332)	302,468	0	0	0	0	0	0	0	0	0	291,136	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Eunice C. Smith Nursing Home** **#** **0008409** **Report Period Beginning:** **01/0102** **Ending:** **12/31/02**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(11,332)	302,468	0	0	0	0	0	0	0	0	0	291,136	45

Facility Name & ID Number Eunice C. Smith Nursing Home # 0008409 Report Period Beginning: 01/0102 Ending: 12/31/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Alton Memorial Hospital	100%			Alton Memorial Hospital	Alton, IL.	Management Services

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	Dietary	$ 279,139	Alton Memorial Hospital	100.00%	$ 554,693	$ 275,554	1
2	V	7	Cafeteria		Alton Memorial Hospital	100.00%	15,178	15,178	2
3	V	10	Medical Records		Alton Memorial Hospital	100.00%	9,539	9,539	3
4	V	21	Administrative & General		Alton Memorial Hospital	100.00%	2,197	2,197	4
5	V	17	Home Office Costs	120,409	BJC Home Office	100.00%	120,409		5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 399,548			$ 702,016	$ * 302,468	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Eunice C. Smith Nursing Home # 0008409 Report Period Beginning: 01/0102 Ending: 12/31/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3		There were no payments to related parties.									3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Eunice C. Smith Nursing Home # 0008409 Report Period Beginning: 01/0102 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number (
Fax Number (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Meals Served	194,680	5	$ 1,673,708	$	64,520	$ 554,693	1
2	7	Cafeteria	FTE's	54,233	33	157,601		5,223	15,178	2
3	10	Medical Records	Gross Revenue	198,667,832	25	654,179		2,896,686	9,539	3
4	21	Finance	Gross Revenue	198,880,801	26	8,153		2,896,686	119	4
5	21	Purchasing	Supplies	5,313,041	41	191,477		57,669	2,078	5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
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23										23
24										24
25	TOTALS					$ 2,685,118	$		$ 581,607	25

Facility Name & ID Number Eunice C. Smith Nursing Home # 0008409 Report Period Beginning: 01/0102 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3	Not Applicable											3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	**TOTAL Facility Related**						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	**TOTAL Non-Facility Related**						$	$			$	14
15	**TOTALS (line 9+line14)**						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Eunice C. Smith Nursing Home **#** 0008409 **Report Period Beginning:** 01/0102 **Ending:** 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 14,421	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 13,435	2
3. Under or (over) accrual (line 2 minus line 1).		$ (986)	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 11,684	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 10,698	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1997		8
1998		9
1999		10
2000		11
2001	13,435	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Eunice C. Smith Nursing Home COUNTY Madison

FACILITY IDPH LICENSE NUMBER 0008409

CONTACT PERSON REGARDING THIS REPORT Paul Bradshaw

TELEPHONE 314-653-5366 FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	23-1-07-12-12-201-009	PT SE NE PART SW NE	$ 13,435.00	$ 13,435.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 13,435.00	$ 13,435.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number Eunice C. Smith Nursing Home # 0008409 Report Period Beginning: 01/0102 Ending: 12/31/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 32,604 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1			1937	$ 21,169	1
2					2
3	TOTALS			$ 21,169	3

Facility Name & ID Number Eunice C. Smith Nursing Home # 0008409 Report Period Beginning: 01/0102 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	64		1966	1966	$ 433,793	$ 10,845	40	$ 10,845	$	$ 395,839	4
5			1968	1968	1,770		Various			1,770	5
6			1968	1968	762		Various			762	6
7			1973	1973	1,000	30	33	30		889	7
8			1980	1980	1,178		Various			1,178	8
	Improvement Type**										
9	A/C Units			1995	222		5			222	9
10	71/2 Ton			1981	6,888		20			6,888	10
11	Water Heater			1981	16,430		15			16,430	11
12	Sprinkler			1981	1,980	79	25	79		1,699	12
13	Painting			1985	13,850		Various			13,850	13
14	Misc Renovation			1988	75,082	5,005	15	5,005		72,573	14
15	Misc Renovation			1992	4,155	208	20	208		2,704	15
16	A/C Units			1989	16,438	1,096	15	1,096		14,796	16
17	Misc Renovation			1990	53,990		Various			53,990	17
18	Plumbing			1966	521,325		Various			521,325	18
19	Incinerator Upgrade			1973	695		5			695	19
20	Misc			1968	790		Various			790	20
21	Misc			1970	190		10			190	21
22	Incinerator			1967	3,825		20			3,825	22
23	Parking/Wheelchair			1983	40,133		12			40,133	23
24	Driveway			1989	4,900		10			4,900	24
25	Driveway			1995	8,972	598	15	598		4,784	25
26	Fence Extension			1990	698	47	15	47		587	26
27	Parking/Walk/Curbs			1966	47,660		Various			47,660	27
28	Misc Landscaping			1968	330		Various			330	28
29	Misc Landscaping			1970	600		Various			600	29
30	Oil & Chip Roadway			1981	3,805		5			3,805	30
31	Wall Construction			1991	5,509	275	20	275		3,163	31
32	Door Frame			1991	1,770		10			1,770	32
33	Concrete			1992	726	48	15	48		384	33
34	Patch & Seal Parking			1994	7,435	620	12	620		5,270	34
35	Door Frame			1995	1,449	145	10	145		1,232	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Eunice C. Smith Nursing Home # 0008409 Report Period Beginning: 01/0102 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Install Water Softener	1995	$ 14,149	$ 1,415	10	$ 1,415	$	$ 10,612	37
38	Window Treatment Lobby	1995	2,138	214	10	214		1,605	38
39	East Dining Room Carpet	1995	2,844		5			2,844	39
40	East Dining Room Alum Door	1995	1,449	72	20	72		540	40
41	East Dining Room Wallcovering	1995	2,845		5			2,845	41
42	Landscape	1995	42,800	2,853	15	2,853		21,398	42
43	Conference Room Renovation	1996	7,916	792	10	792		4,556	43
44	Replace Secondary Signage	1997	9,471	947	10	947		5,682	44
45	Install Vinyl Flooring Rest Rooms	1997	32,700	3,270	10	3,270		19,620	45
46	Elevator Door Protection	1997	1,656	166	10	166		996	46
47	Flat Roof Replacement	1997	82,637	8,264	10	8,264		42,009	47
48	Cabinetry	1997	5,816	291	20	291		1,493	48
49	Corridor Painting	1997	5,771	967	5	967		5,771	49
50	Door fRame Protectors	1997	2,426	244	10	244		1,250	50
51	Interior & Exterior Lighting	1997	20,084	2,014	10	2,014		10,345	51
52	Install Vinyl Flooring Rest Rooms	1997	29,773	2,986	10	2,986		12,357	52
53	Replace Carpet East Dining Room	1998	7,927	1,585	5	1,585		7,397	53
54	Install New Transformer	1998	28,092	1,405	20	1,405		6,322	54
55	Storm Drain Back Parking Lot	1999	8,413	467	18	467		1,635	55
56	Install 4 Smoke Dampers in Basement	1999	6,248	417	15	417		1,459	56
57	Install Wandeguard Locking System	1999	2,162	309	7	309		1,184	57
58	Wallcovering & Paint	2001	8,106	1,621	5	1,621		2,432	58
59	Fire Sprinkler System	2001	193,922	7,757	25	7,757		12,928	59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,797,695	$ 57,052		$ 57,052	$	$ 1,402,313	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Eunice C. Smith Nursing Home # 0008409 Report Period Beginning: 01/0102 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 484,366	$ 47,559	$ 47,559	$		$ 370,848	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 484,366	$ 47,559	$ 47,559	$		$ 370,848	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Nursing Home Busines	1992 Ford Savannah	1991	$ 33,255	$	$	$		$ 33,255	76
77										77
78										78
79										79
80	TOTALS			$ 33,255	$	$	$		$ 33,255	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,336,485	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 104,611	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 104,611	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,806,416	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Not Applicable

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Eunice C. Smith Nursing Home # 0008409 Report Period Beginning: 01/0102 Ending: 12/31/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$ 6,941		$	$		$ 6,941	1
2	Licensed Speech and Language Development Therapist		hrs	1,928					1,928	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs	5,906			65		5,971	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Central Supply						44,771		44,771	13
14	TOTAL			$ 14,775		$	$ 44,836		$ 59,611	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Eunice C. Smith Nursing Home # 0008409 **Report Period Beginning:** 01/0102 **Ending:** 12/31/02

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/02 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$ 23,870,566	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)		7,737,428	3
4	Supply Inventory (priced at)		439,988	4
5	Short-Term Investments			5
6	Prepaid Insurance		634,638	6
7	Other Prepaid Expenses		135,913	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Misc Receivables		2,611,691	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$	$ 35,430,224	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments		525,000	12
13	Land		191,222	13
14	Buildings, at Historical Cost		58,802,301	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost		29,826,078	16
17	Accumulated Depreciation (book methods)		(56,935,186)	17
18	Deferred Charges		2,090,104	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):		34,081,287	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$	$ 68,580,806	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$	$ 104,011,030	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$	$ 1,332,606	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable		1,280,000	29
30	Accrued Salaries Payable		4,118,237	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Other Current Liabilities		7,319,261	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$	$ 14,050,104	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		21,180,000	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Self Insurance Liability		2,708,111	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 23,888,111	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$	$ 37,938,215	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 66,072,815	$ 66,072,815	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 66,072,815	$ 104,011,030	48

***(See instructions.)**

Facility Name & ID Number Eunice C. Smith Nursing Home # 0008409 Report Period Beginning: 01/0102 Ending: 12/31/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 54,753,276	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 54,753,276	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(18,927)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **AMH Net Income**	11,209,558	15
16	Other (describe) **Change in Restricted Fund**	128,908	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 11,319,539	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 66,072,815	24 *

*** This must agree with page 17, line 47.**

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,877,034	1
2	Discounts and Allowances for all Levels	(186,932)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,690,102	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	12,974	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	150	21
22	Laundry	6,690	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 19,814	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc Non Operating	4,513	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 4,513	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,714,429	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	598,726	31
32	Health Care	1,279,044	32
33	General Administration	704,706	33
	B. Capital Expense		
34	Ownership	115,309	34
	C. Ancillary Expense		
35	Special Cost Centers	35,571	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,733,356	40
41	**Income before Income Taxes (line 30 minus line 40)****	(18,927)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (18,927)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,583	2,009	$ 52,968	$ 26.37	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,267	10,642	276,822	26.01	3
4	Licensed Practical Nurses	13,578	15,385	247,616	16.09	4
5	Nurse Aides & Orderlies	48,693	54,780	569,669	10.40	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	666	718	14,776	20.58	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers	4,789	5,242	57,425	10.95	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	1,985	2,200	34,935	15.88	17
18	Housekeepers	9,027	10,108	90,645	8.97	18
19	Laundry	1,630	1,822	15,110	8.29	19
20	Administrator	1,760	2,080	76,779	36.91	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,238	3,581	45,811	12.79	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: Pharmacy	42	46	2,355	51.20	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	96,258	108,613	$ 1,484,911 *	$ 13.67	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Administrator			$ 76,779
Clerical			45,811
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 122,590

B. Administrative - Other

Description	Amount
Corporate Fees	$ 172,555
Bad Debt	9,798
Office Equipment Rental	2,712
Other (See Attached)	14,674
TOTAL (agree to Schedule V, line 17, col. 3)	$ 199,739
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 20,571
Unemployment Compensation Insurance	3,014
FICA Taxes	109,333
Employee Health Insurance	144,618
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Life Insurance	1,316
Long Term Disability	1,769
Pension	49,209
Employee Activities	2,286
Employee Assistance	978
TOTAL (agree to Schedule V, line 22, col.8)	$ 333,094

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	200
Health Care Worker Background Check	
(Indicate # of checks performed)	
Advertising	1,584
Nursing Home Assoc Dues	3,140
Less: Public Relations Expense	( )
Non-allowable advertising	(1,584)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 3,340

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	263
Seminar Expense	934
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,197

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Eunice C. Smith Nursing Home # 0008409 Report Period Beginning: 01/0102 Ending: 12/31/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5	Not Applicable												
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Eunice C. Smith Nursing Home # 0008409 **Report Period Beginning:** 01/0102 **Ending:** 12/31/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Life Services Network $3,140**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **None Added**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **12,224** Line **39**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **35,040**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **No** Indicate the amount. $ **0**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **0**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Ernst & Young** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **See Cover Letter**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.